State of Rhode Island & Providence Plantations

Department of Elderly Affairs

HOME DELIVERED NUTRITION

[ ] State Funds [ ] Federal Funds Title III-C 2

Title of Project: _____

Applicant Agency: _____
_____
_____

Telephone Number: _____ Fax Number: _____

Official (s) authorized to sign:

Name/Title _____
Address _____

Telephone Number: _____ Extension: _____
Fax Number: _____
E-Mail: _____

Project Director: _____
Address: _____

Telephone Number: _____ Extension: _____
Fax Number: _____
E-Mail: _____

Budget Period: From: _____ To: _____

Signature: _____
Chief Executive Officer [Name & Title]

Date: _____

Federal Employee Identification Number: _____ **(9 Digits)**

Is agency part of a municipality? _____ yes _____ no

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

HOME DELIVERED NUTRITION

Name of Agency: _____

_____

B U D G E T S U M M A R Y

	Budget Category	Total	Credit	Net Expense	Administration	Meals
1.	Personnel	$			$	$
2.	Travel					
3.	Building Space					
4.	Utilities					
5.	Supplies					
6.	Equipment					
7.	Contract Services					
8.	Other					
9.						
10.						
	Total	**$**			**$**	**$**

11.	Resources not used as match	$ _____	**Total from page 10 of 10**
12.	Project Net Cost	$ _____	
13.	Resources used as match	$ _____	**Total from page 10 of 10**
14.	Funds requested	$ _____	**Total - per DEA award letter**
		$ _____	**State**
		$ _____	**Federal**

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C-2 FUNDS

Name of Agency: _____

1. P E R S O N N E L

Position	Salaried	Hourly Rate	Hrs/Wk	% Time on Grant	Total	Admin	Meals	Deliv.	Support Service
a.									
b.									
c.									
d.									
e.									
f.									
g.									
h.									
i.									
j.									

Total $_____

Fringe Benefits: Total: $ _____

DEA Use: _____ %_____

Includes, but is not limited to: (Check appropriate box)

Health Insurance	[ ]
Workers' Compensation	[ ]
RI Unemployment	[ ]
FICA	[ ]
Retirement	[ ]
Other (specify)	[ ]

Total estimated salaries/wages/fringe benefits $ _____

Administration	Meals	Delivery	Support Services
$	$	$	$

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C–2 FUNDS
2. ESTIMATED TRAVEL

A. In-State

Estimated # of miles _____
Rate/mile x _____
Total In-State **_____**

Administration	Meals	Delivery	Support Services
$	**$**	**$**	**$**

B. Out of State

Purpose (Including, but not limited to) Estimated Cost

_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____

Total Out-of-State ..... $ _____

Administration	Meals	Delivery	Support Services
$	**$**	**$**	**$**

Total Out-of-State ..... $ _____

Total Estimated Travel _____ $ _____

Administration	Meals	Delivery	Support Services
$	**$**	**$**	**$**

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

3. BUILDING SPACE

		Admin.	Meals	Deliv.	Supt. Serv
Location: ____________________ ____________________					
Annual Rate/Sq. Foot:	$ ________				
Square Footage:	__________				
Annual Expense:	$ ________	$ ______	$ _____	$ ______	$ ______
Location: ____________________ ____________________					
Annual Rate/Sq. Foot:	$ ________				
Square Footage:	__________				
Annual Expense:	$ ________	$ _______	$ ______	$ ______	$ ______
Location: ____________________ ____________________					
Annual Rate/Sq. Foot:	$ ________				
Square Footage:	__________				
Annual Expense:	$ ________	$ ______	$ _______	$ _______	$ _______
Total Building Space:	__________	**$** ______	**$** _______	**$** _______	**$** _______

Administration	**Meals**	**Delivery**	**Support Services**
$	**$**	**$**	**$**

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C–2 FUNDS

Name of Agency: _____

4. U T I L I T I E S

A. Telephone

# of Phones _____
Monthly Rate $ _____ x 12 = $ _____

B. All Other Utilities:

Gas	$ _____	Water $	_____
Heat	$ _____	Sewer $	_____
Electricity	$ _____	Other (specify) $	_____

Total Estimated Utilities: $ _____

Administration	Meals	Delivery	Support Services
$	$	$	$

5. S U P P L I E S

Category	Estimated Cost
a. Office	$ _____
b. Maintenance	_____
c. Health	_____
d. Other	_____
_____	_____
_____	_____
_____	_____
Total Estimated Supplies	**$ _____**

Administration	Meals	Delivery	Support Services
$	$	$	$

"SUPPLIES" – All tangible personal property other than "equipment" as defined in Section 6.

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C–2 FUNDS

6. E Q U I P M E N T

Item	Quantity	Cost Per Unit	Estimated Total Cost
		$	$

Total Estimated Equipment .....$ _____

Administration	Meals	Delivery	Support Services
$	$	$	$

"EQUIPMENT" – tangible, nonexpendable, personal property having a useful life of more than one year and acquisition cost of $5000 or more per unit.

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C–2 FUNDS

Name of Agency: _____

_____

7. C O N T R A C T S E R V I C E S

Services	Estimated Rate	Units of Service	Estimated Total Cost
	$		$

Total Estimated Contract Service _____ $ _____

Administration	Meals	Delivery	Support Services
$	$	$	$

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C–2 FUNDS

Name of Agency: _____

8. O T H E R

Item Service	Estimated Rate	Units of Services	Estimated Total Cost
	$		$

Total Estimated Other ……. $ _____

Administration	Meals	Delivery	Support Services
$	**$**	**$**	**$**

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C–2 FUNDS

Name of Agency: _____

9. OTHER

Administration	Meals	Delivery	Support Services
$	$	$	$

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

APPLICATION FOR TITLE III–C–2 FUNDS

Name of Agency: _____

10. O T H E R R E S O U R C E S

Used as Match	Not Used as Match
1. Cash	1. Cash
Program Income _____ / Meal X # of Meals: _____ $ _____	USDA _____
Subtotal: _____	Subtotal: _____
2. In-Kind	2. In-Kind
	USDA Commodities _____
Subtotal: _____	Subtotal: _____

Total Used as Match: $_____ **Total Not Used as Match : $ _____**

PLEASE REMEMBER TO INCLUDE THESE TOTALS ON YOUR BUDGET SUMMARY TOTAL PAGE.

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

Section I – Applicant Agency

A. Characteristics of Applicant Agency:

1) Briefly describe the history of the agency and its demonstrated capability to implement the proposed project. (Indicate the date of incorporation).

2) Is the applicant agency a minority agency?

YES [ ] NO [ ]

3) Does the project have a Board of Directors? Describe its composition and responsibilities.

YES [ ] NO [ ]

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

B. Project Administration

1) List each staff position, paid or volunteer:

Title _____

Duties _____
_____
_____

Title _____

Duties _____
_____
_____

Title _____

Duties _____
_____
_____

Title _____

Duties _____
_____
_____

Title _____

Duties _____
_____
_____

Title _____

Duties _____
_____
_____

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

(Continued)

2. How many employees, at present, are 60+? _____

3. Describe responsibilities/tasks that volunteers will perform in your agency.

4. Estimated annual unduplicated number of volunteers to be used in your program: _____

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

C. Project Facility

Location:	Date of last Fire Inspection	Date of Last Health Inspection	Covered by applicant's Insurance policy for:

Fire

[ ] Yes
[ ] No

Theft

[ ] Yes
[ ] No

Liability

[ ] Yes
[ ] No

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

D. Coordination with other projects:

1. Describe plans for coordinating with other agencies / organizations.

2. List all agencies with whom the applicant has a current, written, cooperative agreement:

Agency	Purpose	Date Signed

(Attach additional pages if necessary)

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

E. Service Area / Population:

1. What is the proposed service area for this project?

2. Describe the major characteristics of this area.

3. Describe the composition of the elderly population in this area.

Total 60+ _____

% Low Income _____

% Minority _____

% Non-English _____ Speaking

Other _____

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

(Continued)

4. In your agency service area, describe other available services for older persons:

5. What efforts are presently in place or planned to target economic and socially disadvantaged older persons?

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

F. Other

1. Insurance: List insurance coverage maintained by your agency. (Be specific if coverage extends to other persons, locations, etc. not part of your agency).

2. Bonding Insurance: Be specific as to staff / volunteers.

Section I
Attachments Enclosed:

Yes	No	
[ ]	[ ]	List of members of the Boards of Directors
[ ]	[ ]	By-laws of Board of Directors
[ ]	[ ]	List of members of Advisory Committee
[ ]	[ ]	By-laws of Advisory Committee
[ ]	[ ]	Current Organizational Chart
[ ]	[ ]	Copy of applicant agency incorporations papers
[ ]	[ ]	Current Affirmative Action Plan
[ ]	[ ]	Job descriptions for each staff person
[ ]	[ ]	Personnel policies
[ ]	[ ]	Volunteer policies (if not in personnel policies)
[ ]	[ ]	Copy of bonding insurance policy
[ ]	[ ]	Copies of leases / deeds on facilities operated by applicant agency
[ ]	[ ]	Map of service area
[ ]	[ ]	HEW 641 form
[ ]	[ ]	HEW 441 form

Please provide one new set of attachments each Fiscal Year.

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

GRANT APPLICATION NARRATIVE

Section II – Program Objectives

A. Briefly , but specifically outline the goals your agency wishes to obtain in this application:

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

HOME DELIVERED NUTRITION

B. List the objectives to be accomplished by this Project.

Objectives	Target Date For Completion	# Unduplicated Individuals to be served	# Service Units to be Provided	Funded by this Grant	Provided thru another Agency (List Agency)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

HOME DELIVERED NUTRITION

C. List the objectives to be accomplished by this Project.

Objectives	Target Date For Completion	# Unduplicated Individuals to be served	# Service Units to be Provided	Funded by this Grant	Provided thru another Agency (List Agency)
(Continued)					
9.					
10.					
11.					
12.					

Total unduplicated older persons to be served _____ Total socially disadvantaged to be served _____

Total economically disadvantaged to be served _____ Total minority to be served _____

_____

NOTE: The above categories of projected unduplicated persons served will be monitored and analyzed based on submitted actual counts from monthly / quarterly program reports to the state agency.

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

Name of Agency: _____

ANNUAL CERTIFICATION
DRUG-FREE WORKPLACE REQUIREMENTS
DEPARTMENT OF ELDERLY AFFAIRS GRANTEE AGENCIES

This certification is required by the regulations implementing the Drug-Free Workplace Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990 Federal Register require certification by grantees, prior to award, that they will maintain a drug-free workplace. Section 76.630© of the regulations provide that a grantee that is a State may elect to make once certification in each Federal fiscal year (see Section 76.630(b) in regard to mandatory formula grants. The certification set out below is a material representation of fact upon which reliance will be placed when the agency determines to award the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government-wide supervision or debarment (see 45 C.F.R. Part 76, Sections 76.615 and 76.620).

A. The grantee certifies that it will continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employee that the unlawful manufacture, distribution, dispension, possession, or use of a controlled substance is prohibited in the grantee; workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform about:

1. the dangers of drug abuse in the workplace;

2. the grantee's policy of maintaining drug-free workplace.

3. Any available drug counseling, rehabilitation, and employee assistance programs; and,

4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

(c) Making it a requirement that each employee to be engaged in the performance of the grant by giving a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a conditions of employment under the grant, the employee will:

1. abide by the terms of the statement; and

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

ANNUAL CERTIFICATION DRUG-FREE WORKPLACE REQUIREMENTS

2. Notify the employer in writing of his/her conviction for a violation of a criminal drug statute occurring in the workplace no later than five (5) days after such conviction.

(e) Notifying the agency, in writing, within ten (10) calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction.
Employers of convicted employees must provide notice, including position title to: Division of Grants Management & Oversight Office of Management and Acquisition, U.S. Department of Health & Human Services – Room 517 D, 200 Independence Avenue, S. W. Washington, D.C. 20201. Notice shall include the identification number(s) of each affected grant.

(f) Taking one of the following actions within thirty (30) calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted.

1. taking appropriate action against such an employee, up to and including termination, consistent with the requirements of the *Rehabilitation Act of 1973,* as amended, or

2. requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health law enforcement, or other appropriate agency.

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).

B. the grantee may insert in the space provided below the site for the performance of work done in connection with the specific grant; Place of Performance (street address, city, county, state, zip code).

Place of Performance: Name: _____

Address: _____

_____

Name of Agency: _____

Name and Title of Authorized Representative: _____

Signature: _____ Date: _____

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") **hereby agrees that** it will comply with section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HEW regulations (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to subsection 84.5(a) of the regulations [45 C.F.R. 84.55(a)], the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health, Education & Welfare after the date of this Assurance, including payments or other assistance made after such date on applications for federal assistance that were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful mean. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by Department of Health Education and Welfare, or where the assistance is in the form of real or person property, for the period in subsection 84.5(b) of the regulations [45 C.F.R. 84.5(b)].

The recipient employs fifteen (15) or more persons, and, pursuant to section 84.7(a) or the A74 regulations [45 C.F.R. 84.7(a)], has designated the following person(s) to coordinate its efforts to comply with HEW regulations:

_____
Chief Executive Officer

Agency Name: _____
Address: _____

FEIN: _____

_____ _____
Date Signature of Chief Executive Officer

If there has been a change in name or ownership within the last year, please PRINT the former name below:

NOTE: The "A", "B", and "C" followed by numbers are for computer use: Please disregard.
PLEASE RETURN ORIGINAL TO: Office of Civil Rights, Department of Health Education & Welfare, Post Office Box 8222, Washington, DC 20024

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

TITLE VI OF THE CIVIAL RIGHTS ACT OF 1964

_____ *hereby agrees that* it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulations of the Department of health, Education & Welfare (45 C.F.R. Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulations, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, denied the benefits of or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and,

Hereby gives assurances that it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appears below are authorized to sign this assurance on behalf of the Applicant.

Signature: _____

Chief Executive Officer

Agency Name: _____

Address: _____

_____

Telephone Number: _____ Extension _____

State of Rhode Island & Providence Plantations

Department of Elderly Affairs

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influence or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form – LLL, *"Disclosure Form to Report Lobbying"* in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the ward documents for all sub-awards at all tiers (including sub-contractors, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more that $100,000 for each failure.

Agency: _____

_____

Chief Executive Officer

Agency Name: _____

Specific Agency: _____

Address: _____

_____

Date _____